



Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: LAW OFFICE OF CASS BURTON PO BOX 684749 AUSTIN TX 78768-4749	MFDR Tracking #: M4-04-1586-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: Farmington Casualty Co. Box #: 05	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are asking for the same rate of pay from Travelers Insurance on the disputed claim as they paid on the enclosed sample EOB. The sample EOB is from Travelers Insurance. It does not appear that the 'corrected bill' was considered on the Request for Reconsideration.

Amount in Dispute: \$22,359.26

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position statement for consideration in this dispute.

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
1/21/2003-1/24/2003	SDAY, TX4H, INCL, P27M	Inpatient Surgery	\$22,359.26	\$0.00
			Total Due:	\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

This request for medical fee dispute resolution was received by the Division on October 6, 2003.

- U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the Claim Adjudication Process as to the WC Receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 Trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Cass Burton, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
- For the services involved in this dispute, the respondent reduced or denied payment with reason code:
 - SDAY – M – REIMBURSED ACCORDING TO THE STATE PER DIEM RATES.
 - TX4H – F – PER THE TEXAS FEE GUIDELINE PHARMACEUTICALS ADMINISTERED AT ADMISSION & GREATER THAN \$250/DOSE ARE REIMBURSED AT COST PLUS 10%. IF NOT. THE FEE IS INCLUDED IN THE PER DIEM RATE.
 - INCL – M – THIS PROCEDURE IS INCLUDED IN THE BASIC ALLOWANCE OF ANOTHER PROCEDURE.
 - P27M – THROUGH A REVIEW OF ORIGINAL PAYMENT & ADDITIONAL INFORMATION RECEIVED. IT HAS BEEN DETERMINED ORIGINAL INVOICE WAS PROCESSED INCORRECTLY WHICH RESULTED IN THIS ADDITIONAL PAYMENT

3. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401, effective August 1, 1997, 22 TexReg 6264. Review of the submitted documentation finds that the length of stay was three calendar days. The type of admission is surgical; therefore, the standard surgical per diem amount of \$1,118.00 multiplied by the length of stay of 3 days yields a reimbursement amount of \$3,354.00. This amount less the amount paid by the insurance carrier of \$3,354.00 leaves an amount due of \$0.00 for the surgical admission.
4. The Division concludes that the requestor has failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

_____	Grayson Richardson	December 29, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
_____	_____	_____
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.